

COMPASSION FATIGUE IN THE MILITARY CAREGIVER

BY

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USAWC STRATEGY RESEARCH PROJECT

COMPASSION FATIGUE IN THE MILITARY CAREGIVER

by

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ABSTRACT

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Compassion Fatigue (CF) is a critical problem with caregivers throughout the Military who work with combat survivors and their families. There is an urgent need for caregivers at all levels to recognize and receive proper education and/or intervention. This research paper will explore current interventions and process and propose, where applicable, alternative or additional programs, process or intervention to address compassion fatigue, burnout, stress disorder or other debilitating post-traumatic effects.

COMPASSION FATIGUE IN THE MILITARY CAREGIVER

“The study of war should concentrate almost entirely on the actualities of war—the effects of tiredness, hunger, fear, lack of sleep, weather...The principles of war, of strategy and tactics, and the logistics of war are really absurdly simple: It is the actualities that make war so complicated and so difficult.”¹ Former Army Ranger, LTC Dave Grossman, quotes Field-Marshal Lord Wavell in a letter to B.H. Liddell Hart in the book *On Combat*. Grossman’s third chapter, “Sympathetic and Parasympathetic Nervous System: The Body’s Combat and Maintenance Troops,” discusses the body’s autonomic nervous system—what the body does to protect itself for survival when endangered during civilian and military operations. These ‘actualities’ of war lead to the stress reactions that Charles R. Figley called in his research in 1978 ‘delayed stress reactions.’² These stress reactions, Figley states, started to appear in many veterans nine to 60 months after demobilization.³ This discovery by Figley is an important fact in counseling and treatment of trauma. Figley goes on to state that this “*delay*” in clinical manifestations fostered the Nixon administration’s claim that the Vietnam War had resulted in fewer psychiatric casualties than any other war the U.S. had fought.⁴

Background

From the years 1990-1999, the United States Army deployed to 45 operations in the geostrategic environment.⁵ Now in 2009, all branches of United States Military and its members continue to fight an eight plus year war on terrorism/long war. Across the services, military caregivers (chaplains/medical personnel) experience the trauma and stress as does any other military member. Caregivers assigned in the combat zones, hospitals, chapels, units, clinics and Family Life Centers provide for the needs of each

person with absolute dedication. As a result, Compassion Fatigue (CF) is a critical problem with caregivers throughout the Military who work with combat survivors and their families. There is an urgent need for caregivers at all levels to recognize and receive proper education and/or intervention. This paper will explore current interventions, process and propose, where applicable, alternative or additional programs, process or intervention to address compassion fatigue, burnout, stress disorder or other debilitating post-traumatic effects.

The pioneering work on the effects of war on Soldiers, *The Anatomy of Courage*, was authored by Lord Moran in 1945. Lord Moran was a medical officer of the First Battalion of the Royal Fusiliers of England from 1914 to 1917. Later, he served as Winston Churchill's doctor during World War II. His observations during World War II confirmed his earlier observations.⁶ Lord Moran discusses throughout his book the physical and emotional effects of war on all Soldiers to include himself. Lord Moran describes the men's fear and courage during battle and how Soldier's even "in a quiet part of the line, began to crack." He discussed the 'men of stout heart who were brought to that plight by the blast of a shell which damaged their brains. These men had come out of some rending explosion with their skins intact but with disheveled minds.'"⁷ Lord Moran writes,

When I write of the birth of fear I have in mind something more deeply rooted, that has nothing to do with the stage of fright of the novice who does not know if he is going to act badly or well, something that is born of time and stress, which a man must watch lest it come to influence what he does. It appears only in men who have been scarred by months of war; unless the initial plunge is into a battle or intense shelling it may be months before the ordinary man has any trouble. His discovery of danger does not come at once; often it does not come for a long time. At first he has a strange feeling of invulnerability—a form of egotism—then it is suddenly brought home to him that he is not a spectator but a bit of the

target, that if there are casualties he may be one of them. In this sense I find fear mentioned in my diary only once before the spring of 1915, and then only as we might describe a man seized with a fit in the street, something bizarre that was not part of our lives. But as the war dragged on, and fear was no longer an occasional and exotic visitor but a settler in our midst, I got into the habit of watching for signs of wear and tear, that a man might be rested before he was broken.⁸

Lord Moran goes on in his book to discuss his response to war as the medical officer, “If the medical officer with a battalion escapes the responsibility for military decisions which gamble in human life, nevertheless he too has his own distresses. It is not the wounds he binds which matter, it is when something has been destroyed in the make-up of a man that the bloody business of war comes home to him.”⁹

Lord Moran describes the effect of “the bloody business of war comes home to him,” the term Compassion Fatigue was referenced by Carla Joinson in a nursing professional growth article in 1992 to characterize this effect. In the article Joinson quotes Doris Chase, a 20 year veteran of crisis counseling, in describing the traumatic stress nurses developed when caring for patients.¹⁰ Joinson quotes Chase and states that overpowering, invasive stress can begin to dominate us and interfere with our ability to function. We become angry, ineffective, apathetic, and depressed. These symptoms are classified as burnout, particularly when they apply to our work. She also states that though elements of burnout can occur in any setting, a unique form of it, compassion fatigue, affects people in caregiving professions. Unlike burnout, compassion fatigue is linked directly to particular people: nurses, ministers, counselors, and other providers in the caregiving profession.¹¹

Caregivers unaware of their compassion fatigue are at a greater risk of transmission of symptoms to others to include family members. The ancillary effects are defined as secondary trauma or compassion fatigue. Additionally, research that

examined the relationship between religion and spirituality in coping with stress found a positive correlation between spiritual health and immunity to stressful situations. Educational programming and advanced training could play a key role to counselors developing symptoms of Compassion Fatigue.¹²

Charles Figley in 1995 refined the research and theory of Compassion Fatigue to a higher professional level in his book *Compassion Fatigue: Coping with secondary Traumatic stress Disorder in Those Who Treat the Traumatized*. Figley states that some would argue that it is wrong for a practitioner to have deep feelings of sympathy and sorrow for their client's suffering. Yet, systematic studies of the effectiveness of therapy point to the therapeutic alliance between client and clinician, the ability to empathize, to understand and help clients. If it is not present, it is highly unlikely that therapeutic change will take place. Figley goes on to state that the most important ingredients in building therapeutic alliance include the client liking and trusting their therapist. And these feelings are directly related to the degree to which the therapist utilizes and expresses empathy and compassion. Figley suggests that the term compassion fatigue conveys the impact of empathic immersion in another human being's suffering, without pathologizing the clinician.¹³

In Figley's early work with Vietnam Veterans (1978), he noted the profound impact the intense transference and counter transference could have on clinicians empathetically engaged with a combat survivor. He suggested that the symptoms of compassion fatigue may be compounded for clinicians working with combat-related trauma. He also asserted that a clinician working with a combat veteran is confronted

with their “own vulnerability to catastrophe, and it also challenges their moral attitudes about aggression and killings.”¹⁴

Figley states that Compassion Fatigue is a more “user friendly term” for Secondary Traumatic Stress Disorder (STSD), which is nearly identical to Post-traumatic Stress Disorder (PTSD). The principle difference is that Compassion Fatigue refers to those emotionally affected by the trauma of another (usually a client or family member).¹⁵ He defines STSD as the natural consequent behaviors and emotions from knowing about a traumatizing event experienced by a significant other—the stress resulting from helping or wanting to help a traumatized or suffering person.¹⁶ Compassion Fatigue, however, is related to the cognitive schema of the therapist (social and interpersonal perceptions or morale). It is obvious, Figley states, that we can be traumatized by helping suffering people in harm’s way as well as being directly affected by the trauma itself.¹⁷ Table 1 below from Figley’s book (1995) illustrates the suggested distinctions between Primary and Secondary Traumatic Stress Disorder.¹⁸

Primary	Secondary
A. Stressor: Experienced an event outside the range of usual human experiences that would be markedly distressing to almost anyone; an event such as: 1. Serious threat to self 2. Sudden destruction of one’s environs	A. Stressor: Experienced an event outside the range of usual human experiences that would be markedly distressing to almost anyone; an event such as: 1. Serious threat to traumatized person (TP) 2. Sudden destruction of TP’s environs
B. Reexperiencing Trauma Event 1. Recollections of event 2. Dreams of event 3. Sudden Reexperiencing of event 4. Distress of reminders of event	B. Reexperiencing Trauma Event 1. Recollections of event/TP 2. Dreams of event/TP 3. Sudden Reexperiencing of event/TP 4. Reminders of TP/event distressing
C. Avoidance/Numbing of Reminders 1. Efforts to avoid thoughts/feelings 2. Efforts to avoid activities/situations 3. Psychogenic amnesia 4. Diminished interest in activities 5. Detachment/estrangements from others 6. Diminished affect 7. Sense of foreshortened future	C. Avoidance/Numbing of Reminders of Event 1. Efforts to avoid thoughts/feelings 2. Efforts to avoid activities/situations 3. Psychogenic amnesia 4. Diminished interests in activities 5. Detachment/estrangements from others 6. Diminished affect 7. Sense of foreshortened future

D. Persistent Arousal 1. Difficulty falling/staying asleep 2. Irritability or outbursts of anger 3. Difficulty concentrating 4. Hypervigilance for self 5. Exaggerated startle response 6. Physiologic reactivity to cues	D. Persistent Arousal 1. Difficulty falling/staying asleep 2. Irritability or outbursts of anger 3. Difficulty concentrating 4. Hypervigilance for TP 5. Exaggerated startle responses 6. Physiologic reactivity to cues
(Symptoms under one month are considered normal, acute, crisis-related reactions. Those not manifesting symptoms until six months or more following the event are delayed PTSD or STSD.)	

Table 1.

The following table is an example of personal and professional functions that can deteriorate in a caregiver when she or he is suffering with Compassion Fatigue.

Areas of Personal and Professional Function

Cognitive	Emotional	Behavioral	Spiritual	Personal Relationships	Physical Somatic	Work Performance
Lowered concentration	Powerless	Impatient	Question the meaning of life	Withdrawal	Shock	Low Morale
Less self-esteem	Guilt	Withdrawn	Loss of purpose	Decreased interest in intimacy and sex	Sweating	Low motivation
Apathy	Anger/rage	Moody	Decreased self-appraisal	Mistrust	Rapid breathing	Task avoidance
Rigidity	Survivor Guilt	Regression	Pervasive Hopelessness	Isolation from others	Increased heart rate	Obsession about details
Disorientation	Shutdown Numbness	Sleep disturbance	Anger at God	Overprotective as parent/spouse	Breathing difficulty	Dichotomous thinking
Perfection	Fear	Nightmares	Question religious beliefs	Projective anger or blame	Joint and muscle aches	Apathy
Preoccupation with trauma	Helplessness	Appetite changes	Loss of faith in higher power	Intolerance	Dizziness and disorientation	Negativity
Thoughts of self-harm or harm to others	Sadness	Hypervigilance	Greater degree of skepticism	Loneliness	Increase in # and severity of medical concerns	Lack of appreciation
	Depression	Elevated startle response		Increase in interpersonal conflicts	Impaired immune system	Detachment
	Mood swings	Accident prone			Other somatic	Poor work quality and

					complaint	communicati on
	Depleted energy	Easily loses things				Staff conflicts
	Increased sensitivity					Absenteeis m
						Exhaustion and irritability
						Withdrawal from colleagues

Table 2. Examples of Compassion Fatigue/Burnout Syndrome Figley, C (1995; 97)¹⁹

Sprang, Clark, and Whitt-Woosley in their article, “Compassion Fatigue, Compassion Satisfaction, and Burnout: Factors Impacting a Professional’s Quality of Life,” reported several studies on community mental health workers, disaster response teams, and trauma workers.²⁰ The authors state that 17% of the mental health workers met the criteria for STSD and 18% exhibited significant subclinical levels of psychopathology; 64.7% of trauma workers of the Oklahoma City bombing reported significant traumatic stress; and responders of the 9/11 attacks found 27% at extremely high risk, 11.7% at high risk, and 15.4% at moderate risk for developing Compassion Fatigue.²¹ In the authors’ discussion, they noted that caseload of PTSD clients; psychiatrists in their sample experienced higher levels of Compassion Fatigue than other professionals possibly due to their contact with higher numbers of traumatized patients.²²

A study by Rabbi Stephen B. Roberts and other authors, “Compassion Fatigue among Chaplains, Clergy, and Other Respondents After September 11th,” reported on a “diffusing system” conducted by the American Red Cross.²³ The report states that the American Red Cross in New York City instituted a shift defusing system for its spiritual care volunteers starting on September 13th as part of its spiritual care standard

operating procedure (American Red Cross, 1995). All clergy volunteers were debriefed for 15 to 30 minutes at the end of each of their shifts, either individually or as part of a group. Further, those clergy volunteering at Ground Zero and at the morgue were strongly encouraged and given the opportunity to be formally debriefed by a trained mental-health worker near the formal end of the recovery work.²⁴ On June 17th, 2002, the American Red Cross conducted a one-day conference for clergy and other religious leaders. The conference specifically addressed the impact of September 11th. Their findings suggest that a substantial proportion of clergy and others in the tri-state New York area are at significant risk for compassion fatigue. The findings by the American Red Cross study suggest that the procedures of debriefings and defusing may be useful in ameliorating burnout and compassion fatigue.²⁵

Jeni Tyson, Department of Veterans Affairs, published a paper in 2007 on "Compassion Fatigue in the Treatment of Combat-Related Trauma during Wartime". Tyson states that clinicians are faced with the daunting challenge of providing clinical treatment to a complex cohort amidst the collective shared trauma of ongoing war and the shadow of the mass violence of the 9/11 attacks. She goes on to state that ambiguous terror alerts, anthrax scares, suicide bombings, raw video footage of combat operations, and horrific images of military and civilian wounded and casualties, continually exposes the trauma therapist to more than the graphic material presented by their clients. Therefore, the risk of developing compassion fatigue may be exacerbated in clinicians treating combat-related trauma given the frequent and persistent exposure to current traumas in the world.²⁶

The United States Army Institute of Surgical Research at Fort Sam Houston launched a program in 2008 for the Caregiver Community. Colonel Kathryn Gaylord of the Institute is the director of the new Care for the Caregiver program. Colonel Gaylord states, "The program is designed to identify and treat a syndrome called 'compassion fatigue' in military health care providers."²⁷ Gaylord further states that the Institute is starting to notice signs of compassion fatigue in caregivers of wounded warriors. She states that taxed by their deployments and the complicated care of severely wounded service members, caregivers are beginning to exhibit signs of trauma normally reserved for patients. With symptoms such as heightened irritability, anxiety, depression and sleep disturbances, the syndrome bears a marked resemblance to post-traumatic stress disorder.²⁸ Colonel Gaylord explains the difference between compassion fatigue and burnout which is the emotional exhaustion many people experience due to increased workload and institutional stress. Unlike compassion fatigue, burnout does not require or contain a trauma element. Over time, compassion fatigue can lead a caregiver to grow distant from patients or too close. Both can be detrimental to the patients and families. Caregivers are trained to be compassionate, but there is little training in the military on how to handle the stress of compassion.²⁹

Since 11 September 2001 (9/11), the number of Soldiers and Civilians killed in Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) to January 21, 2009, are over 4,864. The numbers of Soldiers wounded since 9/11 is over 33,608.³⁰ Empirical studies support the theory that counselors and medical personnel who work with the trauma of others have an increased likelihood of experiencing a change in their own psychological functioning.³¹

Tyson references in her study of compassion fatigue within clinicians working with combat veterans that previous deterrents to compassion fatigue such as self-care, peer supervision, and individual therapy may not be enough to meet the needs of the clinicians. She goes on to emphatically state that it is an ethical imperative that the complex challenges facing clinicians treating combat trauma are addressed, not only on individual and supervisory level, but on educational, organizational, and societal level as well.³²

Programs

The Chief of Chaplains Strategic Campaign Plan states in Objective 2 that the Chaplaincy will implement policies, programs, and initiatives to “Support Current Global Commitments with Relevant and Ready Unit Ministry Teams (UMTs).³³ Since 29 July 1775, approximately 25,000 Army Chaplains have served as religious and spiritual leaders for 25 million Soldiers and their Families.³⁴ In FY 2000, the MEDCOM Chaplain in a report about the Kosovo deployment reported more than 20 Chaplains in need of trauma intervention.³⁵ Before 2000, no research was found on Compassion Fatigue and Chaplains serving in the United States Army Chaplain Corps.

The Army Chief of Chaplains, Chaplain (Major General) Douglas L. Carver, states in an April 2008 update: “Increased demands on the chaplaincy contribute to a number of challenges confronting the Corps: maintaining the spiritual resilience of our UMT personnel and their Families after repeated deployments; preventing the dangers of “compassion fatigue” and ministerial burn-out among our chaplains; and the challenge of accessioning quality religious professionals during a time of war and future uncertainty.”³⁶ In his address to the Armed Forces Chaplains Board Endorsers,

Chaplain (MG) Carver restated his three critical priorities in support “of our war-weary Army Family”: I – Maintaining the spiritual health and resilience of our chaplains; II – Supporting Army initiatives to sustain the well-being and readiness of Soldiers and their Family Members; III – Continue efforts to recruit more chaplains to meet our increasing manpower requirements as we “Grow the Army” across all components.³⁷ Within the first critical priority, Chaplain Carver addressed three specific means to maintain the spiritual health and resilience of our chaplains. Those three areas are: 1. Promote chaplaincy spiritual resilience; 2. Provide Care for the Caregiver Initiatives; 3. Establish a Pastoral Care Platform-Center for Spiritual Leadership.³⁸ The means to execute this plan will be introduced through retreats, training, and the new department at the United States Army Chaplain Center and School at Fort Jackson, South Carolina which will be fully operational in the summer of 2009.

Chaplain (Colonel) Michael W. Dugal states his mission with the Center for Spiritual Leadership is to confront the present silence regarding the Soldier’s spirit in the dialogue about war’s trauma and effective combat recovery opportunities. It is his argument that acknowledgement of the Soldier’s spirit through a spirit-centric dialogue with senior Army leaders is the initial step toward enlarging the issue of emotional and spiritual recovery from combat trauma not only for chaplains but for Soldiers in general. The Army’s senior leadership needs to participate in the dialogue with physicians, educators, mental health care providers, and chaplains, regarding the Soldier’s spirit. Chaplain Dugal proposes the Soldier’s spirit is a metaphysical reality and requires a voice on its behalf outside the confines of the military chaplaincy. Supportive and

documented research reveals if the Soldier's spirit is neglected it will be at the expense of the Soldier's recovery, resiliency, mission and ultimately the Nation's mission.³⁹

The United States Army Chaplain Center and School (USACHCS) added several modules the Chaplain Officer Basic Leadership Course and the Captain Chaplain Career Course to address compassion fatigue issues. Provider Resiliency Training and a one day retreat are a positive step toward helping caregivers to address possible fatigue issues.⁴⁰ However, the two courses combined are only a total of ten hours of coursework and may not be sufficient. Other possible interventions to consider are: pre and post testing for compassion fatigue on all Chaplains entering resident courses at USACHCS. Also, pre and post testing for all chaplains in a deployment cycle should be conducted. Personal entrance interviews with all Career Course students could also be used to help identify chaplains with compassion fatigue or PTSD issues. All 32 chaplains who entered the Chaplain Captain Career Course in the summer of 2008 had been deployed at least once into a combat zone. A confidential source stated that no personal or professional history was addressed in a one on one or group interview while attending the course.⁴¹ According to other confidential telephone interviews with Career Course Graduates, no surveys were conducted for compassion fatigue, burnout, PTSD or any possible stress issue. The sole measure to address Compassion Fatigue was that students were advised to "get counseling" if the student felt they were having personal stress issues.⁴²

Additional areas to consider for training at USACHCS are the pastoral care of subordinate chaplains by supervisory chaplains during the unit chaplain's train-up for deployment and during deployment. During confidential telephone conversations,

Captain Chaplain's stated that it was peer to peer support and "policing one another" that assisted them spiritually and emotionally during their deployment.⁴³ One chaplain did state that their Corps Chaplain was present upon arrival at home station and was told to request assistance at any time.⁴⁴ Other chaplains that should be tracked during a deployment cycle are the reserve chaplains' activated to fill vacancies in deploying units.

In her book, *Rule Number Two*, Dr. Heidi Squier Kraft expressed these words of acknowledgements to a senior psychiatrist from Operation Iraqi Freedom I, "To Captain Koffman, another OIF I vet: for checking up on us at Al Asad. It did matter to us, very much."⁴⁵ Navy Captain Koffman arrived at Al Asad to "check on his battalion" and thought he would stop by to see how the three psychiatrists were doing. Captain Koffman listened to the doctors for almost two hours. After the senior psychiatrist left, the statement was made, "It's pretty clear he was here today for one reason," Jason said. "He was here to check on us."⁴⁶ Dr. Kraft states in her journal that night, "Later that evening, writing in my journal about our cathartic group, I remembered a book I had had to read in school. *The House of God*, by Samuel Shem, an entertaining and heartbreaking story about medical interns, had almost nothing to do with our experience here—except for one character's words, which popped into my mind now. He said, "How can we care for patients if nobody cares for us?' We never forgot how the captain cared for us that day."⁴⁷ A two hour conversation by a senior service member or supervisor drastically changed the health of a caregiver in the midst of trauma.

Another consideration for assisting returning chaplains from combat is a unit in an Extended Program of Clinical Pastoral Education (CPE). This is a certified program

which runs one day a week for approximately six months. One unit of CPE could assist the chaplains with decompression from the war zone and assist the caregiver in a non-threatening environment to discuss personal and professional issues. This could also be added to the Chaplain Captain Career Course for those chaplains who were unable to participate in a CPE program after returning from combat.

The United States Army Medical Department of Pastoral Ministry offers five quality ministry courses at Fort Sam Houston, Texas. The courses range from five days to two week in length. Chaplains and Chaplain Assistants who are assigned to a Medical Command are the primary attendees. Other chaplains and assistants may attend as slots are available. Lack of unit funds and group size can be a detriment to some Ministry Team (MT) personnel.⁴⁸ This paper does not address a funding solution but exploring how to resource UMTs to attend these programs should be addressed in further research.

Landstuhl Regional Medical Center (LRMC), Germany, developed the Combat Operational Stress Reaction Staff Resiliency (COSR/SR) program to address the trauma and loss of empathy health care providers' face as a result of combat and operational stress. LRMC's Chaplain (Colonel) James R. Griffith states that combat and operational stress is part of the spectrum of emotional and spiritual and psychological reactions that come to people in the aftermath of some sort of trauma. He states that the LRMC's health care providers sometimes experience the secondary trauma of treating those patients because they identify with them very closely.⁴⁹ The Army's new Provider Resilience Training (PRT) program is designed to further that care. The Provider Resilience Training is designed to assist military health care providers who

may be experiencing provider fatigue to “recharge.”⁵⁰ David Douglas, program manager for European Regional Medical Command’s (ERMC) Provider Resilience Training program, states that the program came about as a result of studies of Walter Reed Army Medical Center, where provider fatigue was one of 96 items the Army identified for assessment. ERMC began implementing the PRT assessment in August 2008, and continued through the end of 2008. Douglass states that the assessment shows 60 to 75 percent of ERMC’s health care providers report high job satisfaction, while there are indicators of some form of fatigue among 20 to 25 percent.⁵¹

The Army is in the process of implementing a Comprehensive Soldier Fitness Program which will enhance resiliency and develop a total fitness program for Soldiers, Families, and civilians. The Fitness Program will help them thrive in an area of high operational tempo and persistent conflict.⁵² This program may be an additional means for addressing the specific effects of Compassion Fatigue.

J. Eric Gentry, Anna B. Baranowsky, and Kathleen Dunning in 1997 developed the Accelerated Recovery Program (ARP) for Compassion Fatigue.⁵³ The five-session protocol was designed to address the symptoms of secondary traumatic stress and burnout, or compassion fatigue, in caregivers. Gentry states in his paper that the Accelerated Recovery Program lead to the development of the Certified Compassion Fatigue Specialist Training (CCFST) which is trained by the Traumatology Institute at Florida State University.⁵⁴ The two programs could be additional training possibilities for the military caregivers.

Illustrations

Decompression of Soldiers and Caregivers must become a priority in the resetting of the Military. In 2006 and 2007, I personally observed the negative consequences of Soldiers returning to their home installations without little or no compression time. In 2006, the SETAF headquarters and the 173d Brigade (Airborne) returned to Camp Ederle in Vicenza, Italy. Senior Non-Commissioned Officers (NCOs) in confidential conversations informed me they had left Afghanistan at approximately 0400 that morning and by 1700 were eating dinner with their families. The NCOs were actually aware and concerned with how they would handle the change. They would not begin their reintegration training for 24 hours. The Soldiers desperately wanted to be with their families but were fearful of how they would respond or react to 'normal' home noises.⁵⁵

One week after his return from Afghanistan a Soldier was hit by a civilian train at 0500 in the morning after spending the entire night walking from bar to bar in Vicenza, Italy. A second Soldier received minor injuries and was released from the hospital. Weeks later (Memorial Day 2006), two Soldiers from the same Brigade were literally dropped off at the front gate of Camp Ederle. Both Soldiers were unconscious. One Soldier was pronounced dead at the scene and the second Soldier was revived and rushed to the civilian hospital. During the reintegration briefings at Camp Ederle, Soldiers would arrive at 0900 still intoxicated from the previous evening's drinking activities. The instructors could smell the alcohol on the Soldiers as they walked by to take their seats. Drinking alcohol was the way the Soldiers were decompressing after a year of combat in Afghanistan. To alleviate some of these dangerous behaviors all

Soldiers, at all levels, redeploying from a combat environment should be staged at a rest site for several days prior to reaching their home installation.

In March 2007, I arrived at the Medical Brigade in Heidelberg, Germany. The brigade had returned from a deployment in Iraq in September 2006. The task force Medical Brigades' mission was to provide joint Health Service Support (HSS) in support of MNC-I full spectrum operations; implements focused partnership and transition assistance in order to facilitate the development of the Iraqi healthcare system. The unit personnel treated over 9,900 total patients in seven hospital locations to include the transfer of 1,500 Iraqi patients to Host Nation hospitals.⁵⁶

As I met the Soldiers in the headquarters, I began to notice dysfunctional or signs of dysfunctional behavior in many of the individuals at all rank and ages. The first was my own Chaplain Assistant. The Soldier appeared to be exhibiting many of the symptoms listed in Table 2 above. I administered the Figley Compassion Fatigue survey to the Soldier. The results showed the Soldier to be clearly experiencing Compassion Fatigue. I counseled with the Soldier and requested he immediately seek counseling with another chaplain or medical caregiver. As I continued to observe the unit's Soldiers, I addressed my concerns to the leadership of the Brigade. I confronted the leadership on the stress level of the unit and how the leader's actions and treatment of the unit's Soldiers could propagate the complications.

I held many counseling sessions and held stress management classes for the entire company. The medical headquarters had not decompressed properly after returning to Germany. Some of the leadership remained at the same high intensity level as they had experienced in Iraq. With this high intensity level, the unit's Soldiers had

not decompressed from the stress level they carried in Iraq. After discussions with the leadership, all leaders began to recognize their own intensity levels and many began to modify their behavior. Also, through individual counseling and continued visits to staff offices, the stress level began to return to a normal garrison exertion level. This is only two examples of units who have deployed to combat zones and not properly decompressed from the enormous trauma of war. Military Chaplains who deploy with these units return with the same level of stress and yet are expected to counsel and minister on a daily basis usually without any decompression of their own. This exacerbates any personal trauma the caregiver experiences which can lead to compassion fatigue or other health issues.

The Carlisle Project, of Carlisle, Pennsylvania, by the Alban Institute in 1989 was conducted “to revitalize the clergy of the Presbytery of Carlisle through a project that would focus on their personal health and professional skills.”⁵⁷ The report stated that a large percentage of the clergy tested high on the Clergy Burnout Inventory; were also administered the Clergy Life Changes Inventory; the Strain Response Inventory and had marital and substance abuse issues.⁵⁸ Oswald outlined the variety of obstacles to effective clergy support groups. Oswald’s outline is listed below:

1. We as clergy are mostly trained and conditioned to be lone rangers. We are more adept at giving help than receiving it. We have difficulty asking for what we need from others to sustain our own health.
2. We all want support yet fear our individuality might be diminished. The model of strength for our culture is that of rugged individualism as personified in characters like the cowboy or detective. These individuals give of themselves selflessly in heroic effort while remaining autonomous at the fringe of society. Large numbers of clergy and laity see the effective pastor as playing a similar role. Generally, this is truer of men than of women; the need for support

and more collegial skills is greater among clergymen than clergywomen.

3. Clergy often feel competitiveness and distrust. If our pastorates are in the same region, we believe we are competing in the same market for the loyalty and support of lay resources.
4. The plain hard work of developing trust is prelude to helpful, supportive relationships.⁵⁹

Oswald's list is transferable to the military chaplaincy, however, the additional stress of combat and separation from family support can amplify the obstacles. Also, I disagree that the need for a support system is greater among clergymen than clergywomen. In the military setting, I believe there is less of a support system for female chaplains than their male counterparts. On most military installations and combat areas of operation, there is only one clergywoman assigned. This can lead to equal if not greater than stress factors due to inadvertent isolation.

Conclusion

Since Lord Moran's first observations of 'wear and tear' of combat in World War I; the first use of the term Compassion Fatigue in the article by Joinson in 1992; and the prolific research by Charles Figley and others since the Vietnam War, questions have now been raised over the 'care of the caregiver'. Whether it is the chaplain, chaplain assistant, medic, clergy, nurse, physician, police officer, social worker, or fireman, caregivers are beginning to discuss the issue of Compassion Fatigue and their healing. The untreated affects of Compassion Fatigue not only affects the caregiver it also affects the counselees and the families of both. These untreated symptoms carry with them the potential to disrupt, dissolve, and destroy careers, families, and even lives. Many Army Chaplains, several years after the event, still grieve the loss of one of their

fellow chaplains and this loss should be treated with great respect. Army Chaplains or medical caregivers who go undiagnosed or are apprehensive about receiving treatment are highly dedicated individuals wanting to serve their God and their country. As Gentry stated in his research the good news is that the symptoms of Compassion Fatigue appear to be responsive to being treated and rapidly ameliorated.⁶⁰ Gentry's final statement of his 2002 article is a powerful echo to the Strategic Plan of the Army Chaplaincy. Gentry states that with skilled intervention and determination, care providers with compassion fatigue can undergo a profound transformation leaving them more empowered and resilient than they were previously and therefore better equipped to act as "givers of light."⁶¹

Endnotes

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